aneurysm wall, reducing the overlap while leaving the bifurcation and limbs stable within the distal aneurysm, and ameliorating the proximal displacement forces.

We have experimented with alternate designs, including locking the bifurcate portion to the tubular portion of the device, or improving the crush resistance of stents deployed within fenestrations. However, the same fundamental principles apply to any design regardless of any subtle differences. They include the following:

(1) Ensure optimal proximal fixation (active fixation in healthy aorta).
(2) Ensure optimal distal fixation (rest bifurcate portion on the bifurcation and secure the limbs within healthy segments of the iliac arteries).
(3) Ensure maximal overlap between the bifurcate and tubular components.
(4) Allow the two components to reach a minimal stressed state, mitigating the downward forces on the proximal portion of the device.

These principles are adhered to in our practice, and perhaps explain the absence of this complication in all implants after 2004.

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Comment on ''Long-Term Results using Catheter-directed Thrombolysis in 103 Lower Limbs with Acute Iliofemoral Venous Thrombosis''

Dear Editor,

I have read with interest the article published by Baekgard et al. regarding a single center's experience with catheter directed thrombolysis of iliofemoral venous thrombosis.[1] This article demonstrates potential benefits of thrombolysis in the treatment of deep vein thrombosis, especially in the prevention of late complications. However, some additional data would have been helpful. Anticoagulant treatment may affect recurrence rate and therefore, indirectly, local complication rate. Treatment duration is a matter of debate but probably should be tailored according to patient characteristics.[2,3] It would therefore have aided to our understanding if Baekgaard and colleagues added the information regarding their patient's anticoagulation regimens and adherence. Furthermore, graded compression stockings may have yet another beneficial effect in preventing the post-phlebitic syndrome.[4] Report of the use of such devices in the studied population could have added more to our understanding of the actual benefits of catheter directed thrombolysis in preventing late complications of deep vein thrombosis.

Thank you.

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Response to comment on ''Long-Term Results using Cateter-directed Thrombolysis in 103 Lower Limbs with Acute lliofemoral Venous Thrombosis''

Dear Dr Weinberg,

Thank you very much for your comments to our publication. We agree that several additional procedures could be important for our excellent results in this series, and among these the beneficial of using compression stockings and securing sufficient anticoagulation treatment. However, we doubt that these additional treatment modalities are the main course for the success of catheter-directed thrombolysis for deep venous thrombosis in our material. The fact that the immediate thrombus removal is almost 100 % is in our mind unrelated to the factors mentioned above. In the abstract we have prescribed compression stockings and anticoagulation using warfarin for at least 1 year, and indefinitely in patients with severe thrombophilia. Approximately one third of the patients are receiving long-life anticoagulation. The long term results most logically must be due to the early thrombus removal thereby saving patency and valve function in these patients with iliofemoral deep venous thrombosis. In our experience we seldom observe spontaneous thrombolysis in patients with iliofemoral deep venous thrombosis.

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